STATEMENT OF THE

AMERICAN DENTAL ASSOCIATION

TO THE

SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES
COMMITTEE ON APPROPRIATIONS
UNITED STATES HOUSE OF REPRESENTATIVES

ON

SUPPORT OF DENTAL AND ORAL HEALTH-RELATED PROGRAMS AT THE DEPARTMENT OF HEATH AND HUMAN SERVICES

March 29, 2006

Summary

On behalf of the American Dental Association (ADA), President Robert M. Brandjord, D.D.S., an Oral and Maxillofacial Surgeon from Eden Prairie, Minnesota, will testify before the subcommittee on Labor, Health and Human Services, Education and Related Agencies on March 29 at 10:15 am.

- The ADA strongly objects to the Administration's elimination of funding for the Title VII general, pediatric and public health dentistry residency programs, which are instrumental in training dentists who work in underserved communities and treat Medicaid, SCHIP or other underserved populations, particularly those with special needs. The ADA recommends that the Committee restore and continue funding for Title VII dental residencies at least to the FY 05 funding level of $8 million.
- The Centers for Disease Control and Prevention's Division of Oral Health (DOH) supports state- and community-based programs to prevent oral disease, promote oral health nationwide and foster applied research to enhance oral disease prevention in community settings. The Association recommends that the Committee restore the proposed budget cut of $660,000 for the Division of Oral Health and increase CDC funding by $4 M, with $2 M in FY 07 and $2M in FY 08.
- Since FY 2002, the Committee has supported the inclusion of $5 million for oral health projects in the Maternal and Child Health Bureau (MCHB), Special Projects of Regional and National Significance (SPRANS) account. The ADA recommends continued funding at this level.
- The Dental Health Improvement Act allows states great flexibility to conduct needed programs that fail to fall under other grant programs. The ADA recommends that $5 million funding be continued for this program.
- Health professions education and training programs have a critical role in the recruitment and retention of minority and disadvantaged students and faculty. ADA recommends $3 million for the FLRP and a total of $135 million for the other Minority and Disadvantaged Student Programs.
- The Ryan White HIV/AIDS Dental Reimbursement Program increases access to oral health services for people living with HIV/AIDS; ensures that dental and dental hygiene students and dental residents receive the most current training; and assists in defraying the rising non-reimbursed costs associated with providing such care by dental education institutions. The ADA requests that $19 million is available for the Ryan White Program.
- NIDCR is the only Institute within the NIH that is committed to oral health research and it remains the primary public agency that supports dental behavioral, biomedical, clinical, and translational research. NIDCR provides the intellectual foundation for the nation's 6,500 oral health researchers and nearly 170,000 clinicians. It funds 93 percent of oral health research at NIH and 99 percent of oral health research training, providing over $200 million in research support to the nation's dental schools. This funding represents more than 75% of total NIH support to dental schools and is crucial to maintaining viability of research in schools in more than 30 states. More than 80% of the NIDCR's funding goes to researchers at nearly 130 institutions in 44 states. The ADA is recommending that the Committee fund the NIDCR at $410 million.

On behalf of the American Dental Association (ADA), which represents over 152,000 dentists, thank you, Mr. Chairman and members of the subcommittee for the opportunity to comment on FY 2007 appropriations for federal dental programs. I am Bob Brandjord, a practicing oral surgeon and president of the American Dental Association.

Within the Department of Health and Human Services (HHS) there are oral health programs that provide dental research and education, as well as oral health prevention and community-based access programs. Each of these programs is important as a means of helping to ensure access to oral health care, especially for the disadvantaged in our society.

Oral health has improved dramatically in recent years but there are wide variations in oral diseases and conditions among racial and ethnic groups, between poor and more affluent populations, and between healthy Americans and those with medical conditions and disabilities. Furthermore, our aging population increases the number of people with disabilities and many of them will retain their teeth. According to the HHS's Administration on Aging, the number of people 65 years or older will grow from 12.4% of the population in 2000 to 20% by 2030, so the need for adequate funding of dental education, research and community based programs will only intensify. In addition, there is growing evidence linking oral disease and systemic disease, which can be extremely costly to treat, so it is becoming increasingly clear that effective oral health prevention and treatment can result in significant health care savings.

Mr. Chairman, periodontal research like the research supported by this Committee at the National Institute of Dental and Craniofacial Research produces significant breakthroughs for understanding the relationship of the mouth to the body. But to successfully translate those findings into improved patient care, oral health care programs rely on several federal funding streams, that when woven together, as some states and dental schools have done, create a comprehensive approach to improving the oral health of the nation. Unfortunately, the Administration has once again proposed a budget that eliminates or reduces many of these programs and we fear that the outcome will be reduced services and care to those who most need oral health treatment and an unraveling of these interconnected programs.

Health Resources and Services Administration
Dental Education - General Dentistry and Pediatric Dentistry Residencies

The ADA strongly objects to the Administration's elimination of funding for the Title VII general, pediatric and public health dentistry residency programs. Title VII dental residency programs are instrumental in training dentists who work in underserved communities and treat Medicaid, SCHIP or other underserved populations, particularly those with special needs. Furthermore, while in training, these residents staff clinics that provide treatment at low or no cost for patients in Community Health Centers, Indian Health Service facilities, and Ryan White HIV/AIDS programs. The elimination of these programs will significantly decrease access for those patients.

As the Association has testified in the past, some states have fewer than 10 pediatric dentists. Last year Congress severely cut these programs and at this time we do not know the effect of those actions other than that no new grants will be available this year. HRSA needed almost $6 million

more to fund all of the current primary care medical and dental grants in the program. It is our understanding that a decision has not been made as to how they will direct those cuts. While it will be difficult to absorb these cuts, discontinuing this funding for FY 2007 will make further recovery difficult, if not impossible. Therefore, the ADA recommends that the Committee restore and continue funding for Title VII dental residencies at least to the FY 05 funding level of $8 million.

Centers for Disease Control and Prevention
Division of Oral Health

In its efforts to help build effective state oral health programs, the Centers for Disease Control and Prevention's Division of Oral Health (DOH) supports state- and community-based programs to prevent oral disease, promote oral health nationwide and foster applied research to enhance oral disease prevention in community settings. Despite significant oral health needs and challenges, most state oral health programs have limited infrastructure and capacity, which are necessary for states to meet the oral health needs of citizens.

With CDC's support, state Oral Health Programs are building effective oral health prevention programs and reducing disparities among disadvantaged populations. States are:

- Expanding water fluoridation and dental sealant programs targeted to high-risk children
- Tracking disease trends throughout the lifespan
- Developing state plans to improve oral health
- Forming partnerships and creating oral health coalitions

Also, CDC works intensively with several states to help oral health programs develop core components (infrastructure and capacity) needed to successfully achieve positive health outcomes in their states. CDC provided $3.8 million in FY 2005 to 12 states.

Some successful outcomes of this program include --

- Colorado collected data on oral health status and access to dental care, published a model Oral Disease Burden Document, and developed a fact sheet on oral health for decision makers.
- Illinois formed the IFLOSS oral health coalition that advanced a statewide survey of oral disease in school children and worked to secure a legislative mandate to assure oral health screenings for all children in grades K, 2, and 6.
- New York's surveillance efforts identified low coverage of dental sealants in New York. This information enabled state policymakers to increase funding by $1 million to strengthen sealant efforts in New York.

Funding to the 12 states and one territory expires at the end of FY 07. The Association recommends that the Committee restore the proposed budget cut of $660,000 for the Division of Oral Health and increase CDC funding by $4 M, with $2 M in FY 07 and $2M in FY 08. With this level of funding **the Division can fund all the states that have previously expressed both a need and an interest in this assistance. This would include those states currently funded and those that have yet to receive this CDC support.**

Maternal and Child Health

Since FY 2002, the Committee has supported the inclusion of $5 million for oral health projects in the Maternal and Child Health Bureau (MCHB), Special Projects of Regional and National Significance (SPRANS) account. The SPRANS account funds oral health programs in f**ifty-one** states and territories. They have allowed States to devote attention to oral health activities that would not otherwise be possible and to individualize their plans for state-specific needs. Many states have used their funding to partner with others to initiate dental sealant programs at no cost for children in low income areas. The state of Illinois offers one of the best examples. They worked with 60 local health agencies and were able to apply over 910,000 dental sealants to more than 341,320 elementary school children. Michigan also used its funding for dental sealants and developed a WIC/Head Start oral health intervention preventive dental program for pregnant women, infants and children under 3 years. The Association urges the Committee to continue this funding at the same level of $5 million to maintain its commitment to improving oral health for children.

Health Care Safety Net Amendments Act

Mr. Chairman, the CDC and MCH oral health programs have proved to be essential for helping states reach the most vulnerable populations who need oral health care. But even when taken together, they don't cover all of the needs. The ADA was very pleased that the Committee included $2 million for The Dental Health Improvement Act in the FY 06 conference report. We expect that this funding will provide 18-20 grants of about $100,000 each for projects that focus on maintaining an adequate dental workforce and addressing the needs of underserved populations. An estimated 25 million Americans live in areas lacking adequate dental services. For these people, oral health treatment and prevention programs remain out of reach. The geographic disparity is most felt within rural and frontier communities. The grant program would allow these communities to utilize funds to establish or expand dental facilities or set up mobile clinics. Funds could also be used to support dental residency programs or establish teledentistry programs for distance-based dental education. The Dental Health Improvement Act allows states great flexibility to conduct needed programs that fail to fall under other grant programs. The ADA recommends that $5 million funding be continued for this program.

Health Resources and Services Administration
Health Professions Education and Training Programs
For Minority and Disadvantaged Students

Health professions education and training programs have a critical role in the recruitment and retention of minority and disadvantaged students and faculty. These programs are crucial if we

are to address concerns with health disparities. The ADA is very disappointed that the president's budget eliminates funding for: Loans for Disadvantaged Students, the Centers of Excellence program, the Health Careers Opportunity Program, and the Faculty Loan Repayment (FLRP) program for FY 2007. There is currently a faculty recruitment crisis in dental education with approximately 280 dental faculty vacancies remaining unfilled. If we cannot recruit the best and brightest to academia and research, many of the oral health care concerns discussed in this testimony cannot be addressed. Underrepresented minority recruitment into dental education is a serious problem. In 2004, the first-year enrollment of underrepresented minority students in dental school was only 12.3% of the total first year dental student enrollment. In 1990, the percentage of underrepresented minority students in the first year class was 13.8% of the total first year enrollment. Thus, an increased investment in the FLRP would help address these concerns. ADA recommends $3 million for the FLRP and a total of $135 million for the other Minority and Disadvantaged Student Programs.

Ryan White HIV/AIDS Dental Reimbursement Program (Part F, Ryan White CARE Act)

The Ryan White HIV/AIDS Dental Reimbursement Program increases access to oral health services for people living with HIV/AIDS; ensures that dental and dental hygiene students and dental residents receive the most current training; and assists in defraying the rising non-reimbursed costs associated with providing such care by dental education institutions. It is important to note that current appropriations allow Ryan White program funds to offset only a fraction of unreimbursed costs of providing care to those served. In fact, the FY 2005 reimbursement level covered only 55 percent of the unreimbursed costs of providing care, which were 21 % higher than unreimbursed costs reported in 2004. (from $13,855,084 in 2004 to $16,774,707 in 2005.)

In addition, financial factors related to income and insurance coverage make it difficult for people with HIV/AIDS to access oral health care in any other setting. Patients with compromised immune systems are more prone to oral infections like periodontal disease and tooth decay. In 2002 a study published in the *Journal of the American Dental Association* (*133 JADA 1343*) found that providing HIV-infected people with regular diagnostic and preventive care significantly reduced the need for more complex and costly services. In order to ensure dental schools have the necessary funding to provide adequate oral health care to this sensitive patient population, the ADA requests that $19 million is available for the Ryan White HIV/AIDS Dental Reimbursement Program.

National Institute for Dental and Craniofacial Research (NIDCR)

NIDCR is the only Institute within the NIH that is committed to oral health research and it remains the primary public agency that supports dental behavioral, biomedical, clinical, and translational research.

NIDCR provides the intellectual foundation for the nation's 6,500 oral health researchers and nearly 170,000 clinicians. NIDCR funds 93 percent of oral health research at NIH and 99 percent of oral health research training. NIDCR provides over $200 million in research support to the nation's dental schools. This funding represents more than 75% of total NIH support to

dental schools and is crucial to maintaining viability of research in schools in more than 30 states. More than 80% of the NIDCR's funding goes to researchers at nearly 130 institutions in 44 states.

Institute-sponsored research continues to link oral infection to such systemic diseases as diabetes, cardiovascular disease (heart attack and stroke) and adverse pregnancy outcomes (preterm birth and low birth weight). One of the most significant break throughs in dental research has been in the area of salivary diagnostics. Saliva serves as the "mirror" of the body's health, because it contains the full range of proteins, hormones, antibodies, and other substances that are frequently measured in standard blood tests. Research afforded by your support of NIDCR is yielding exciting advances, which is focusing on rapid and early identification of people who are at the highest risk for a particular disease. For example, one group of researchers has been using salivary diagnostic technology to analyze the saliva of kidney patients before and after they undergo dialysis, identifying possible biomarkers for kidney disease. Another team has been developing a lab-on-a chip diagnostic system to detect proteins and substances that may signal potential oral cancer or breast cancer – hopefully leading to a highly sensitive and reliable way to identify this disease very early on.. Other research projects are underway to test the use of salivary diagnostics to detect the SARS virus, corona virus, asthma and other disease biomarkers.

These powerful research advances cannot be achieved without the intellectual talent to carry out the research. Yet there is a critical shortage of clinical oral health researchers. Through the National Research Service Award program, the NIDCR has been supporting institutional training with specific focus on clinical research methodology. In FY 2006, NIDCR funded two institutional training grant applications. However, current budget levels will not allow for a previously planned reissuance of the request for applications for this type of training. As a result, we will not reach the critical mass of new clinical investigators that are needed over the next decade.

Because of investments in clinical research, clinical trial planning grants, and in clinical trial infrastructure, NIDCR's research community is now better equipped to direct large-scale clinical trials. These studies are necessary to clarify potential links between oral and systemic diseases and disorders such as preterm birth, cardiovascular disease, diabetes, arthritis, and pulmonary disease. Such studies a have high potential for translation into clinical practice and for improving the health status of all Americans. NIDCR's ability to fund such trials will be limited under current budget levels.

<u>The ADA is recommending that the Committee fund the NIDCR at $410 million to continue to advance its research agenda.</u>

Mr. Chairman, that concludes my testimony, I would be glad to answer any questions you might have.

Robert M. Brandjord, D.D.S.

Biography

Robert M. Brandjord, who practices the dental specialty of oral and maxillofacial surgery in Burnsville, Minnesota, is president of the American Dental Association.

Dr. Brandjord's previous responsibilities with the ADA include serving a four-year term on the ADA Board as the trustee from the Tenth District. As a trustee, he served on key committees and task forces.

He is a past president of the Minnesota Dental Association and the Minnesota Society of Oral and Maxillofacial Surgeons.

Dr. Brandjord's hospital staff affiliations include serving as Department of Surgery Chief at Fairview Ridges Hospital, Burnsville. He has taught at the University of Minnesota Dental School (UMDS) in the Department of Oral and Maxillofacial Surgery.

He received his dental degree from UMDS and completed his training in oral and maxillofacial surgery at Detroit-Macomb Hospitals and the Children's Hospital of Michigan in Detroit.

Dr. Brandjord and his wife Pamela reside in Eden Prairie, Minnesota.

Written Disclosure Requirement

Pursuant to House Rule XI, clause 2 (g), the American Dental Association and ADA witness Dr. Robert M. Brandjord state that neither has received any funds from federal grants or contracts in fiscal years 2006, 2005, or 2004.